STATEMENT OF PROCEEDINGS FOR THE REGULAR MEETING OF THE LOS ANGELES COUNTY COMMISSION FOR CHILDREN AND FAMILIES

KENNETH HAHN HALL OF ADMINISTRATION
500 WEST TEMPLE STREET, ROOM 739
LOS ANGELES, CALIFORNIA 90012

Monday, January 23, 2012

10:00 AM

AUDIO LINK FOR THE ENTIRE MEETING. (12-0441)

Attachments: AUDIO

Present: Chair Curry, Vice Chair Berger, Vice Chair Kang, Commissioner Franzen, Commissioner Kleinberg, Commissioner McClaney, Commissioner Murray, Commissioner Olivas, Commissioner Rudnick, Commissioner Sorkin and Commissioner Trevino-Powell

Excused: Vice Chair Friedman, Commissioner Biondi and Commissioner Williams

Call to order. (11-5504)

The meeting was called to order by Chair Curry at 10:07 a.m. and self-introductions of attendees were made.

I. ADMINISTRATIVE MATTERS

1. Approval of the Agenda of January 23, 2012. (11-5506)

By Common Consent, there being no objection (Vice Chair Friedman, Commissioner Biondi and Commissioner Williams being absent), the Agenda for the meeting of January 9, 2012 was discussed. No action was taken by the Commission due to lack of quorum.

2. Approval of the Minutes from the meeting of January 9, 2012. (11-5507)

By Common Consent, there being no objection (Vice Chair Friedman, Commissioner Biondi and Commissioner Williams being absent), the Minutes for the meeting of January 9, 2012, were continued to the next Commission Meeting, due to a lack of quorum.

Attachments: SUPPORTING DOCUMENT

II. REPORT

3. Chair's Report by Patricia Curry, Chair, for January 23, 2012. (11-5509)

Chair Curry reported on the following:

- **A memo regarding cell phone usage during Commission Meetings will be forthcoming. Commissioners and members of the audience were asked to please have their cell phones turned off or have their settings changed to vibrate during Commission meeting to avoid disruptions.**

- **At the System Team Leadership (SLT) meeting attended by Commissioner Sorkin, it was reported that there is a possibility of additional funding in the Mental Health Services Act (MHSA), over the coming year. On February 2, 2012, there will be a workgroup meeting in the Commission office to discuss potential allocation options of these funds. Those interested are welcome to attend.**

- **The Faith-Based Committee meeting scheduled for January 26, 2012 has been cancelled. A new date will be forthcoming.**

After discussion, by Common Consent and there being no objection (Commissioners Freidman, Biondi, and Williams being absent), this item was received and filed.

III. PRESENTATIONS

4. Presentation on the Katie A. Exit Strategies by the Departments of Children and Family Services (DCFS), County Counsel, and Mental Health DMH):

- Adrienne Olson, LCSW, Child Welfare Mental Health Division, DCFS
- Greg Lecklitner, DMH
- Brandon T. Nichols, Principal Deputy County Counsel (11-5511)

A Power Point presentation was presented by Ms. Adrienne Olson, Mr. Greg Lecklitner and Mr. Brandon T. Nichols.

Mr. Nichols gave a brief overview of Katie A. case and the exit conditions that were recently approved by the Federal Court who has jurisdiction over Katie A. The case stemmed from a class action lawsuit filed in 2002 against the State and Los Angeles County for failure to assess the mental health needs and inadequate mental health services which resulted in the disruption of placement for children. In 2003, Los Angeles County resolved its portion of the case in a settlement agreement which required the County to make systemic improvements to better assess the mental health needs of children and to better provide services designed to meet those needs. Within this settlement agreement, there were four (4) primary objectives, which included that children:

1. **Promptly receive necessary individualized mental health services in their own home or in a family-like setting appropriate to their needs;**
2. **Receive care and services needed to prevent removal from their families or to meet their needs for safety, permanence, and stability;**
3. **Be afforded stability in their placement, whenever possible; and**
4. **Receive care and services consistent with good child welfare and mental health practice and the requirements of law.**

The objectives were translated to have specific exit conditions that would satisfy all involved (the plaintiff, the County, the Courts and the children). They are:

1. **Successful implementation and completion of a Strategic Plan that includes the programs, contracts, and staffing that the County will have to put in place in order to satisfy the court and the plaintiff.**

2. **Data indicators derived from the data bases of the Departments of Mental Health (DMH) and Children and Families (DCFS) with clear measures of how the program is performing.**

3. **Passing score on a Quality Service Review (QSR). Teams were developed to audit case files that include interviews of all persons involved. Then the results were compared to the standard. The teams then come together, review all findings and submit a formal report that is publically reported. QSRs provide information to the court showing there is a measurement of improvement and something is being done.**

In response to questions posed by the Commission, Mr. Nichols noted the QSRs are an on-going progress. The children are always included in the scope of all QSRs. QSRs are designed to drive system reform and to develop good mental health practices.

Ms. Olsen stated there are seven (7) components of implementing the Strategic Plan that includes the primary activities that DMH is focused on and supports that include funding, training, case load reduction as well as data tracking and QSR specific to the exit conditions.

1. **Mental Health Screening and Assessments**
   - **DMH implemented a Coordinated Services Action Team (CSAT).**
   - **DMH developed a Mental Health Screening Tool - means by which compliance will be demonstrated of the children with mental health needs entering and currently in the system.**
   - **In 2010 DMH redesigned CSAT and its Mental Health Screening Tool to distinguish between acute, urgent and routine screens.**
   - **DMH developed a Referral Tracking System (RTS) that provides elements to assure children were being referred properly and as needed.**

In response to questions posed by the Commission, Ms. Olsen stated there are three tracks of children being referred: 1. Newly detained children; 2. Newly opened cases; non-court services (basically for family maintenance); and 3. Existing DCFS population.

2. **Mental Health Service Delivery**
   - **Access**
   - **Quality of service**

Mr. Lecklitner noted that for planning purposes, 50% of those children within the child welfare system with open cases need mental health services. Of that 50%, 1 in 3 need more intense mental health services versus a more routine dosage. Currently, there is a 66% success rate of those being screened, while in 2004, access to mental health services was at 28%. Today the Department is at 60% which indicates that it is moving in the right direction.

The quality of services were initially underpowered and standard. Mr. Lecklitner noted that for planning purposes, it was decided to expand the Wraparound Program, which served as a model for both the County and State case. Currently there are approximately 2,600 filled wraparound slots, and by 2014 it is expected to have 4,200 filled wraparound slots. Additionally, there is the Treatment Foster Care that ordered the County from having zero beds to having 300 beds of Treatment Foster Care. This program includes the foster parent as a member of the treatment team, as these parents often get very difficult kids to work with. This Treatment Foster Care is also referred as a group home for one. There are two different models -- the Multi-dimensional Treatment Foster Care (MTFC) that is an evidence-based practice, and the Intensive Treatment Foster Care (ITFC), which is the State model that is more flexible.

In response to questions posed by the Commission, Mr. Lecklitner and Ms. Olsen noted that the State, through the ITFC/MTFC Programs provide the County a rate of $1,800 ITCF/$2,400 MTCF per month, to pay the foster parents. They noted that Orange County, receives $3,200 per month. The Foster Family Agency (FFA) receives a rate and after certain requirements take the rate to pay the members of the team as well as the foster parent. Although the FFAs are allotted $4,000, the contracts that are currently in place in the County allows for the lower rate of $1,800 and $2,400. Although foster parents are important, the real goal is permanency.

Mr. Nichols added that one of the problems with treatment for foster cases and the wraparound programs is that there is no consistency across the State, which is one of the reasons the State was sued. However, the State has an obligation to assure that every child has access to services. Currently, through a State settlement negotiation, the State has agreed with the plaintiff, that the State has to provide for services to every County in the State. Additionally, the State has agreed to set aside funds in its budget for these types of programs. Hopefully, by June 2012 the State should have a manual ready that indicates certain regulations that must be followed for programs like ITFC and MTFC.

It is anticipated that IV-E Waiver funds will be available for the County from the State. The Plaintiffs position is that IV-E Waiver funds be used for mental health treatment and not just for foster case placement, thereby shifting the funding burden to Medi-Cal rather than Title IV-E. The County has spent lots of money buying services under Title IV-E, and hopes that when the State issues its manual, the burden for services will shift from Title IV-E to EPSDT (Early and Periodic Screening, Diagnosis and Treatment), as services will be more defined at medical services, rather than foster case and support services. EPSDT funding will free up Title IV-E money to be used elsewhere.

Mr. Lechitner continued to say, the State settlement should result in a medical documentation manual to clarify billing, as well as some financial assistance. Currently the County is using approximately $2 million to fund the wraparound slots. The Departments of Probation, Children and Family Services, and Mental Health have developed Core Practice Models (systems of care) to conduct business and QSRs to change the basic practice levels.

Mr. Nichols concluded his comments, indicating that the success of the goals is measured of when the County can exit the case. Once the County has achieved those goals, the court will allow the County to exit. It is estimated that the County will not have fully implemented the plan until 2014. Therefore exit would most likely be until after 2014.

After discussion, by Common Consent and there being no objection, (Commissioners Freidman, Biondi, and Williams being absent) this item was received and filed.

Attachments: SUPPORTING DOCUMENT

5. Presentation on Psychotropic Medication by DCFS and DMH:

- Dr. Sophy, Medical Director, DCFS
- Lisa Sorensen, DCFS
- Dr. Roderick Shaner, DMH
- Dr. William Arroyo, DMH
- Dr. Hanu Damerla, DMH
- Dr. Christopher Thompson, DMH
- Dr. Gia Crecelius, DMH (12-0124)

Two Power Point presentations were presented.

Dr. Sophy, Ms. Sorensen, and Dr. Shaner presented an update on the Psychotropic medications, and how DCFS is working with DMH in the proper handling of medication, follow-ups, and reporting. Dr. Shaner noted the last time they spoke before the Commission, there were in depth discussions on:

- **Practices of medication --what needed to be looked at;**
- **Tracking medication;**
- **Collaboration between DCFS and DMH to ensure children received proper medication;**
- **Looking at all the issues surrounding medication; and**
- **Meeting the obligation of quality despite some apparent challenges.**

Over the last four years, DMH and DCFS established quarterly meetings where they have worked through various medication issues, protocols, data, and have tracked results in both individual concerns and trend concerns.

Ms. Sorensen added that in 2008 Judge Nash officially ordered DCFS to follow the Judicial Council's protocol, and subsequently, mandated the protocol through the Delinquency Court in 2010, for Probation. In 2009, DCFS was again ordered by Judge Nash through the Dependency Court to produce progress reports within 40 days of court approval of a new or significantly increased dosage of a psychotropic medication being administered to a child. This measure was set in place to identify if children were having ill effects from the medication and if caregivers were not properly administering medication. Our most recent efforts with regards to tracking psychotropic medication is through an electronic tracking of Psychotropic Medication Authorization (PMA) forms which are immediately included to the child's file.

This process helps when DCFS comes in contact with a child in an emergency situation and the PMA is readily available resulting in the child's needs being more effectively addressed.

In response to questions posed by the Commission, Dr. Sophy and Ms. Sorensen reported the following:

- **There is an initial PMA, followed by a 40-day wrap-up with an interview to a child, caregiver, and anyone involved to address any issues that the child may have with the medication.**

- **From the medical perspective, weight gain takes a while. Any change in the child must be documented.**

- **Group Homes and FFAs are audited for compliance with the PMA protocol.**

- **The PMA cycle takes about 2 weeks:**
  - **Step 1: Request for Medication - This request comes from the doctor that explains to the caregiver the reason for the medication, dosage instructions, and possible effects of the medication, including possible side effects.**

  - **Step 2: DCFS PMA Desk sends a copy of the PMA to the Dependency County PMA Desk and to the parents/ guardians advising them of the PMA being requested and then the PMA is completed. [Day 2-3]**

  - **Step 3: Dependency County PMA Desk enters the PMA into the tracking system and forwards a copy of the PMA to minor's attorney, to the parents'/guardians' attorney, and to Juvenile Court Mental Health Services (JCMHS). [Day 3-4]**

  - **Step 4: JCMHS reviews the PMA, makes a recommendation to approve or deny to the court and returns the PMA to the PMA Desk Clerk. If necessary, they contact the doctor who issued the PMA to clarify the recommendation. [Day 4-6]**

  - **Step 5: Dependency Court PMA Desk prepares the PMA request to be reviewed by the Judicial Officer. [Day 4-7]**

- **Step 6: Judicial Officer sets the matter for a hearing if needed, rules on the PMA request, and completes the JV223 (court ordered approval or denial of the PMA request) authorization document. This is when the 40-day progress report is assigned to DCFS for new medication. The Judicial Officer then forwards the PMA to the Court Assistant. [Day 7-10]**

- **Step 7: Court Assistant/Judicial Assistant either sets the matter for a hearing and notifies all parties, or returns the PMA to the Dependency Court PMA Desk Clerk. [Day 7-10]**

- **Step 8: Dependency Court PMA Desk Clerk provides copies of the JV223 to the attorneys, parents and CASA (Court Appointed Special Advocates), JCMHS, prescribing physician and DCFS PMA Desk [Day 7-8]**

- **Step 9: DCFS PMA Desk Clerks electronically includes PMA to child's case, sends a copy to the CSW (Child Support Worker), PHN (Public Health Nurse), and caregiver. They also notify the D-Rate staff when the Court has ordered a follow-up Progress Report on the new medications [Day 10-14]**

- **Although PMA is a good way of tracking, there are limitations. PMAs are only good for 6 months and only one PMA can be active at a time. After 6 months, PMA's must be resubmitted. Additionally, PMAs are not required when: 1) The child is in a voluntary placement; 2) The child is detained and placed, but no dispositional orders have been made by the court; and 3) The child is supervised by the court and placed with a parent. Consent to administer psychotropic medication must be obtained from the parent in these situations.**

In response to questions posed by the Commission, Dr. Sophy and Dr. Shaner stated the following:

- **There are currently approximately 3,000 children on psychotropic medication; however, efforts continue to bring that number down.**

- **Departments have limited purview of what private psychiatrist do. Department's ability to monitor psychiatrist comes only when Departments have psychiatrists in a provider panel. Psychiatrists are credentialed every few years. D-rate evaluators are all licensed mental health professionals. Teachers and personnel that staffs school**

Functions attended by children are frequently contacted, and schools Are furnished with satisfaction surveys. Additionally, DMH works Closely with the schools. Furthermore, there are various kinds of skill development techniques that are also used to meet the child's needs.

Later, Dr. Crecelius and Dr. Tesoro presented a Power Point presentation that provided an overview of the Juvenile Court Mental Health Services (JCMHS) and the services they provide to the Dependency Court and reported the following:

- **There are three (3) distinct services provided by JCMHS:**
  - **Review of PMA forms;**
  - **Clinical consultation to Dependency Court; and**
  - **A DMH representative is available to provide services in the Pasadena Delinquency Court**

- **JCMHS is a multi-disciplinary team consisting of a child/adolescent psychiatrist, a psychiatric clinical pharmacist, a clinical psychologist, several psychiatric nurses and several psychiatric social workers. Although there are approximately 8,000-12,000 PMA requests that are reviewed by JCMHS, numbers reflect the number of requests not necessarily the number of children. A child can have multiple requests over the course of the year. JCMH clinically review the request and make a recommendation to the court on whether the PMA request should be approved, denied or approved with modifications. JCMHS does not withhold consent. It is the Judicial Officer that provides consent.**

- **The PMA request review process has specific practice parameters for the use of psychotropic medications in children and adolescents. JCMHS use the DMH practice parameters and the American Academy of Child and Adolescent Psychiatry practice parameters. A workgroup team meets quarterly to review the request based on the following:**

  - **Upon initial review of most of the children, a recommendation is generally made for non-medication treatment first, including individual therapy, group therapy, or trauma therapy if the child has wraparound services, or any other non-medication treatments.**

- **Upon review and determination that a medication regiment appears safe and effective, a review page is signed and forwarded to the court. If the regiment does not appear safe or effective or is questionable, JCMHS issues a "no" recommendation to the medication. JCMHS makes every attempt to contact the physician for clarification, pulls court files for information, and conducts additional research, or alerts the Judicial Officer if necessary. JCMHS has a two-day time constraints in which to conduct a review. If JCMHS conducts a review and still has questions or concerns, it may recommend a 30-day period to allow time for follow-up.**

- **JCMHS provides consultation services to the Dependency Courts and accepts referrals for questions about mental health issues. Referrals must have a mental health component.**

- **Member of the JCMHS team open the case and conduct face-to-face evaluations with the child/ adolescent, caregivers, group homes, staff and subsequently provide a report to the court with recommendations. JCMHS does not conduct psycholgical/psycheducational testing. If there are additional concerns, JCMHS may go to the Judicial Court and request to review the child's case outside of the PMA's request process.**

In response to questions posed by the Commission, Dr. Crecelius and Dr. Tesoro stated that in the initial Group Medication Request Comparison for three quarters of 2009, 2010 and 2011, there was a percentage of children that had 5 or 6 types of medication. However, after further review of the report, it was discovered that some children have 6 medications.

After discussion, by Common Consent and there being no objection, (Commissioners Freidman, Biondi, and Williams being absent), this item was received and filed.

Attachments: SUPPORTING DOCUMENT

IV. DCFS INTERIM DIRECTOR'S REPORT

6. DCFS Interim Director's Report by Philip L. Browning, Interim Director, DCFS. (11-5510)

Mr. Browning reported on the following:

1. **The proposed State budget shows some departments will be affected more than others. DCFS is part of the realignment on the budget. There is a provision that would add $200 million to the child welfare program that was initially $400 million.**

2. **The County is also working on its budget. All Departments are going through a 1, 2 and 3% budget reduction drill. The CEO (Chief Executive Officer) is hopeful that the County tax revenue will not require additional cuts. The drills are done just in case. Some departments have taken a bigger cut just because of the amount of actual County money that is available to them.**

3. **The IV-E waiver is getting ready for its evaluation period. This evaluation will show if the funds are being well-spent. There will be a meeting in two weeks in Sacramento to talk about where IV-E will be going forward.**

4. **There will be a meeting in about two weeks with the Regional Developmental Centers to talk about how the Department and the centers can develop a better working relationship. Commissioners were asked to e-mail Mr. Browning their input on examples of how to address the working relationship of the two. There were surveys sent out and the Department anticipates finishing their review in February 2012.**

5. **DCFS is 45% into AB12 conversions. Some youth that have moved that would like to remain with the County as opposed to just exiting out. Some of the goals in the Strategic Plan is to increase self-sufficiency and have them go to college or some other educational opportunity.**

6. **DCFS is looking for a sponsor for legislation to allow the DOJ (Department of Justice) to make a modification to the manual process and access information about the child on a real-time basis. The object is to strengthen families. Dr. Browning will**

forward any information to the Commission as it develops. He asked that the Commission provide any support they can on sponsorship.

After discussion, by Common Consent and there being no objection, (Commissioners Freidman, Biondi, and Williams being absent) this item was received and filed.

V. MISCELLANEOUS

Announcements

7. Announcements for the meeting of January 23, 2011. (11-5513)

There were no announcements given by the Commissioners.

Matters Not Posted

8. Matters not on the posted agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting of the Commission, or matters requiring immediate action because of an emergency situation or where the need to take action arose subsequent to the posting of the agenda. (11-5493)

There were no matters posted.

Public Comment

9. Opportunity for members of the public to address the Commission on items of interest that are within the jurisdiction of the Commission. (11-5514)

No members of the public addressed the Commission.

Adjournment

10. Adjournment for the meeting of January 23, 2012. (11-5515)

The meeting was adjourned by Chair Curry at 12:17 p.m.